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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JUDITH REYES** **aka JUDITH M. GONZALEZ** **3732 Ramona Drive** **Riverside, CA 92506** **Registered Nurse License No. 733944** **Public Health Nurse Certificate No. 74183** Respondent.	Case No. 2013-283 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 7, 2008, the Board of Registered Nursing issued Registered Nurse License Number 733944 to Judith Reyes, also known as Judith M. Gonzalez (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed.

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3. On or about September 29, 2008, the Board of Registered Nursing issued Public Health Nurse Certificate Number 74183 to Respondent. The Public Health Nurse Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and

experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG

11. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(J) and is a dangerous drug pursuant to Business and Professions Code section 4022.

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FACTS

12. On or about November 5, 2010, the Board received information from the California Department of Public Health (DPH) that Respondent was among five licensed registered nurses, all employed at Sharp Grossmont Hospital (Sharp) in San Diego, who failed to adhere to the hospital's written policy and procedure in that they all failed to ensure the right medication dose was administered to a patient pursuant to the physician's orders. As a result of the complaint, the Division of Investigation (DOI) conducted an investigation into the allegations.

13. Respondent was hired by Sharp on January 5, 2009. As part of her initial and ongoing training, Respondent was responsible for complying with Sharp's Policy and Procedure No. 30035.99 entitled "*Medication Administration.*" The purpose of the policy and procedure was to provide guidelines for the safe and accurate administration of medications to patients and proper documentation in the medical record. This policy and procedure contained a Red Rule, which is a critical behavior in a policy or procedure that is essential to safety. Specifically, in administering medications, the Red Rule required that staff adhere to the "6 Rights" (right patient, right drug, right dose, right route, right time, and right rationale). The nursing staff was required to maintain patients' medication history in Cerner, an electronic medication administration record system used by Sharp.[1]

14. On the morning of October 15, 2010, a 59-year-old female (hereinafter referred to as Patient 309), presented to the Sharp emergency room complaining of a headache and abdominal pain that radiated to her back. Patient 309 was diagnosed with acute pacreatitis and was admitted as an inpatient at approximately 16:19 hours. At 17:37, the attending physician ordered 0.5 mg hydromorphone every two hours as needed for moderate pain, for a total of four doses. However,

[1] An Electronic Medication Administration Record (eMAR) is a point-of-care process that utilizes barcode reading technology to monitor the bedside administration of medications. When a nurse uses this technology, medication orders appear electronically in a patient's chart after pharmacist approval. The technology also alerts nurses electronically if a patient's medication is overdue. Before administering medication, a nurse is required to scan the bar codes on the patient's wristband and then those on the medication itself. If the two do not match the approved medication order, or if it is not time for the patient's next dose, a warning is issued.

the physician entered an order to discontinue the hydromorphone at 18:12. The orders were reviewed and verified by an LVN and a pharmacist.

15. Patient 309 was subsequently transferred to Sharp's Nursing Unit (2 East) just after midnight on October 16, 2010, and was assigned to the care of Nurse Rosario. The 2 East admitting physician continued the order for hydromorphone with the same dosing parameters (0.4 mg for mild pain, 0.6 mg for moderate pain, and 0.8 mg for severe pain).

16. At approximately 02:50 on October 16, 2012, Nurse Rosario went to Cerner to access Patient 309's eMAR. When Nurse Rosario opened Patient 309's eMAR, she later reported that she saw text for the physician's orders clumped together and it was hard to read. Nurse Rosario believed she saw an order for 4 mg hydromorphone. When Nurse Rosario attempted to withdraw 4 mg. of hydromorphone from Pyxis, a dose alert ("speed bump") appeared. Nurse Rosario was required to obtain a witness in order to pull a 4 mg. syringe of hydromorphone (instead of the 1 mg. syringe ordered by the physician). Nurse Binu confirmed the withdrawal of 4 mg. hydromorphone without questioning the speed bump or verifying that it was the correct dosage.

17. Nurse Robert had been helping Nurse Rosario with charting and patient care. When Nurse Rosario got called away to attend to a Code Green on one of her patients, she gave Nurse Robert the 4 mg. syringe of hydromorphone to administer it to Patient 309. Nurse Robert verified the medication on the computer and saw that Nurse Rosario had already charted that it had been administered to Patient 309.

18. Respondent was charting in the medication room when she was approached by Nurse Robert. Nurse Robert asked her to open the eMAR for Patient 309. Nurse Robert asked Respondent to verify the patient's information and that both he and Respondent saw that 4 mg. of hydromorphone had been charted. Neither Nurse Robert nor Respondent verified the physician's orders for Patient 309.

19. At around 04:18, a Code Blue (for cardiac arrest) was called for Patient 309. Patient 309 was resuscitated, but she had experienced anoxic brain injury and remained unresponsive. Life support was withdrawn on October 18, 2010, and she died that afternoon.

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20. The Deputy Medical Examiner for San Diego County listed Patient 309's cause of death as arteriosclerotic cardiovascular disease and the manner of death as "natural."

21. The Department for Health and Human Services conducted a review of the incident and prepared a summary statement of deficiencies. The report found that the nurses involved in the care of Patient 309 failed to follow written policy and procedure related to medication administration, failed to ensure that medications were administered in accordance with the orders of the practitioner responsible for the patient's care, and failed to ensure that the medication administration record accurately reflected the medication administration time. The report stated that "The four RN's from 2 East failed to adhere to the hospital's written policy and procedure titled Medication Administration (#30035.99). Specifically [RN Rosario], [RN Binu], [RN Robert], and [Respondent] all failed to ensure that the right dose was administered to Patient 309 as it was prescribed, and when presented an opportunity to stop the medication error failed to verify the correct dose."

CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by California Code of Regulations, title 16, section 1442, in that on or about October 16, 2010, while employed by Sharp, as detailed in paragraphs 12-21, above, Respondent failed to follow written policies and procedures related to medication administration, and failed to ensure that medications were administered in accordance with physician's orders. Respondent failed to comply with the hospital's Red Rule which required she adhere to the "6 Rights" (right patient, right drug, right dose, right route, right time, and right rationale). Respondent failed to ensure that the right dose was administered to Patient 309 as it was prescribed, and when presented an opportunity to stop the medication error, she failed to verify the correct dose. Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 733944, issued to Judith Reyes, also known as Judith M. Gonzalez;

2. Revoking or suspending Public Health Nurse Certificate Number 74183, issued to Judith Reyes;

3. Ordering Judith Reyes to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: October 12, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012703876